Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Future Planning Model

Integrated Care System NI
Draft Framework

Targeted Stakeholder Consultation

Document

19 July 2021

Contents

Introduction

1. We would welcome your views on the Integrated Care System NI Draft Framework.

2. The draft framework is attached at **Annex A**.

3. This consultation document provides some background to the project and details how you can respond to the consultation.

Background

4. A Review of Commissioning (undertaken in 2015) found the current system to be overly bureaucratic and lacking in clarity of accountability of decision making, detailing the need for changes to be made in the way we plan, manage and deliver our services. The need for such change was subsequently reinforced by the Bengoa Report "Systems not Structures"[1] and reflected in our response *Health & Wellbeing 2026: Delivering Together*[2].

5. *Delivering Together* clearly articulates the requirement for local providers and communities to plan integrated and continuous health and social care for their local population whilst specialist services should be planned and delivered on a region-wide basis.

6. In order to deliver against this vision development of a future planning model based on an integrated care system (ICS) approach has been commenced.

7. An ICS approach brings together partners within the HSC but also beyond, including partners in the voluntary and community sectors and local government, to plan, manage and deliver services based on the needs of the local population.

[1] https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

[2] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together

8. The integrated care model will:

   - Observe the principles of increased autonomy and accountability at local decision making levels;
   - See the delegation of decision-making and funding to local levels, with the exception of regional and specialised services;
   - Allow for planning, management and delivery of specialised services at a regional level; and
   - Be supported underpinned by an outcomes-based approach.

9. Ultimately, as the model and partnerships mature, it would see local groups take more control over planning and funding for services delivered within their areas, in order to deliver the most appropriate services to meet the needs of their population in line with agreed strategic objectives.

How is an Integrated Care System different?

10. The current commissioning process, led by the Health and Social Care Board (HSCB), translates the agenda set by the Minister of Health (reflected in the Commissioning Plan Direction) into a comprehensive, integrated Commissioning Plan for health and social care services. The Commissioning Plan is subsequently developed and agreed in consultation with the Public Health Agency. The HSCB then work with service providers to develop business cases which set out in detail how services will be commissioned.

11. Local Commissioning Groups (LCGs) support the planning and commissioning function by leading on needs assessment activities, providing local health intelligence, and overseeing the day to day transactional activities with their respective HSC Trusts.

12. In addition, they ensure the involvement of independent contractors, particularly General Practitioners, in the commissioning of local services.

13. LCGs are currently supported by Integrated Care Partnerships (ICPs) in service co-ordination and collaboration in the co-design of newly commissioned services.

14. However, our existing system and approach as whole has not reached its full potential. Limitations have emerged with services being commissioned with individual providers rather than on the basis of a whole systems approach to meet identified need.

15. HSC Trusts are not a constituent of LCGs which has been a limiting factor in integrated planning. Whilst Trusts are a key partner in ICPs, they currently operate with a relatively narrow scope.

16. It is clear that the current system often operates in silos and that local autonomy has not materialised as was originally envisaged. LCGs will cease upon closure of the HSC Board, currently planned for 31 March 2022. The importance of ensuring that we continue to plan and manage services informed by local input and intelligence is embedded in the ICS approach.

Integrated Care System

17. At its core, an ICS model is about partnership and collaboration between sectors and organisations. The purpose is to improve the health and wellbeing of the populations they serve. It is about delivering services and support in a joined-up way, not in silos or isolation.

18. Key to this approach is that it seeks to harness not just the strengths of our health and social care sector but also by looking beyond to what can be achieved when we work in partnership with the voluntary and community sector, with local government and other statutory partners, and with our service users.

19. Importantly, HSC Trusts will be a constituent part of the ICS model which will also build on and incorporate the work of ICPs.

20. A fully developed ICS will have a great deal more delegated authority and responsibility for managing resources for local population areas and to act

flexibly to deliver health and wellbeing outcomes rather than predetermined service models.

21. The link with wider partners is particularly important and an ICS will have the opportunity to invest in addressing the determinants of health and wellbeing with a greater focus on health improvement and early intervention.

22. It is important to recognise that the development of a fully integrated care system model with associated funding and accountability frameworks is an extremely complex undertaking and one which can take a significant period of time to develop. Work will be progressed on a phased basis to reflect this.

Draft Framework

23. In line with the above, early work has been undertaken to produce a draft framework to underpin the model.

24. The document provides a blueprint for the future planning and managing of health and social care services in Northern Ireland. It provides an overview and guidance on the proposed model to allow the system to design and adopt the relevant approaches, policies and structures required to implement the ICS model in NI.

25. The draft framework includes detail on the population health approach, definitions, vision, values and principles, and how regional and local levels will be developed and operate. It ensures that clarity and direction is provided where appropriate, but that there is flexibility built in to the system to allow each area to develop and evolve based on the identified needs in their area and resources and assets available to them.

26. The draft framework is attached at **Annex A**.

Impact assessments

27. An Equality Screening, Disability Duties and Human Rights Assessment exercise has been undertaken. This document is available online. No significant impacts have been identified at this stage and therefore it is determined that a full impact assessment is not required.

How to Respond

28. We are seeking views on the draft framework, and invite written responses by no later than **Friday 17th September 2021.**

29. You can respond online by accessing the Northern Ireland Government Citizen Space website and completing the online survey via the following link: https://consultations.nidirect.gov.uk/doh-1/future-planning-model-integrated-care-system-ni.

30. We would prefer responses using Citizen Space, however, if you wish to send an email or hard copy of your response please send it to:

    Department of Health
    Organisational Change Directorate
    Annex 3
    Castle Buildings
    Stormont
    Belfast
    BT4 3SQ
    OrgChgDir@health-ni.gov.uk

31. The consultation questions are listed in **Annex B**. A word version template for response can be accessed online via the following link should you wish to provide a hard copy/electronic response as opposed to completing the online questionnaire: https://www.health-ni.gov.uk/consultations/future-planning-model-targeted-stakeholder-consultation.

32. When you reply, it would be very useful if you could confirm whether you are replying as an individual or submitting an official response on behalf of an organisation. If you are replying on behalf of an organisation, please include:

    your name;
    the name of your organisation; and
    an e-mail address.

33. If you have any queries, or wish to request a copy of the draft framework in an alternate format, please contact the Department using the email address below to make your request: OrgChgDir@health-ni.gov.uk

Privacy, Confidentiality and Access to Consultation Responses

34. For this consultation, we may publish all responses except for those where the respondent indicates that they are an individual acting in a private capacity (e.g. a member of the public). All responses from organisations and individuals responding in a professional capacity may be published. We will remove email addresses and telephone numbers from these responses; but apart from this, we will publish them in full. For more information about what we do with personal data please see our consultation privacy notice (**Annex C**).

35. Your response, and all other responses to this consultation, may also be disclosed on request in accordance with the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR); however all disclosures will be in line with the requirements of the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (UK GDPR) (EU) 2016/679.

36. If you want the information that you provide to be treated as confidential it would be helpful if you could explain to us why you regard the information you

have provided as confidential, so that this may be considered if the Department should receive a request for the information under the FOIA or EIR.

What Happens Next

37. Following the close of the consultation on **Friday 17th September 2021**, all responses and feedback will be collated for review by the Department of Health, and a consultation report will be produced. The consultation report will be shared with respondees.

Annex A – Draft Framework

Attached separately

Annex B – Consultation Questions

A word version of the consultation response questions is available on Department's website: https://www.health-ni.gov.uk/consultations/future-planning-model-targeted-stakeholder-consultation

Number	Question
1.	**Section 3 describes and defines what an Integrated Care System (ICS) model is which provides the blueprint for how we will plan, manage and deliver services in NI moving forward.** **Do you agree that this is the right approach to adopt in NI?**
2.	**Section 5 sets out the Values and Principles that all partners will be expected to adhere to.** **If applicable, please comment on anything else you think should be included.**
3.	**In line with the detail set out in Section 7 do you agree that the Minister and the Department's role in the model should focus on setting the overarching strategic direction and the expected outcomes to be achieved, whilst holding the system to account?**
4.	**Section 8 sets out what the ICS model will look like when applied to NI. It is based on the principles of local level decision making which will see a shift of autonomy and accountability to local ICS arrangements. Do you agree with this approach?**
5.	**As detailed in Sections 8 and 9, a Regional Group will be established to undertake an oversight, co-ordination and support function for the ICS. Do you agree with this approach?**

6.	**As detailed in Sections 8 and 10, do you agree that the establishment of Area Integrated Partnership Boards (AIPBs) is the right approach to deliver improved outcomes at a local level?**
7.	**Section 10 of the framework provides further detail on the local levels of the model, including the role of AIPBs.** **Do you agree that AIPBs should have responsibility for the planning and delivery of services within their area?**
8.	**Do you agree that AIPBs should ultimately have control over a budget for the delivery of care and services within their area?**
9.	**As set out in Section 10, do you agree with the proposed minimum membership of the AIPBs?**
10.	**As set out in Section 10 of the framework (and noting the additional context provided in Annex A of the document), do you agree that initially each AIPB should be co-chaired by the HSC Trust and GPs?**
11.	**The framework allows local areas the flexibility to develop according to their particular needs and circumstances.** **As set out in Section 10, do you agree that the membership and arrangements for groups at the Locality and Community levels should be the responsibility of the AIPBs to develop, determine and support?**
12.	**Other/General comments:**

Annex C: Consultation Privacy Notice

Data Controller Name: Department of Health (DoH)

Address: Castle Buildings, Stormont, BELFAST, BT4 3SG

Email: OrgChgDir@health-ni.gov.uk

Telephone: 02890520533

Data Protection Officer Name: Charlene McQuillan

Telephone: 02890522353

Email: DPO@health-ni.gov.uk

Being transparent and providing accessible information to individuals about how we may use personal data is a key element of the Data Protection Act (DPA) and the UK General Data Protection Regulation (UK GDPR). The Department of Health (DoH) is committed to building trust and confidence in our ability to process your personal information and protect your privacy.

Purpose for processing

We will process personal data provided in response to consultations for the purpose of informing development of our policy, guidance, or other regulatory work in the subject area of the request for views. We will publish a summary of the consultation responses and, in some cases, the responses themselves but these will not contain any personal data. We will not publish the names or contact details of respondents, but will include the names of organisations responding.

If you have indicated that you would be interested in contributing to further Department work on the subject matter covered by the consultation, then we might process your contact details to get in touch with you.

Lawful basis for processing

The lawful basis we are relying on to process your personal data is Article 6(1)(e) of the UK GDPR, which allows us to process personal data when this is necessary for the performance of our public tasks in our capacity as a Government Department.

We will only process any special category personal data you provide, which reveals racial or ethnic origin, political opinions, religious belief, health or sexual life/orientation when it is necessary for reasons of substantial public interest under Article 9(2)(g) of the UK GDPR, in the exercise of the function of the department, and to monitor equality.

The lawful basis we are relying on to process your personal data is Article 6(1)(e) of the GDPR, which allows us to process personal data when this is necessary for the performance of our public tasks in our capacity as a Government Department.

How will your information be used and shared?

We process the information internally for the above stated purpose. We don't intend to share your personal data with any third party. Any specific requests from a third party for us to share your personal data with them will be dealt with in accordance the provisions of the data protection laws.

How long will we keep your information?

We will retain consultation response information until our work on the subject matter of the consultation is complete, and in line with the Department's approved Retention and Disposal Schedule Good Management, Good Records (GMGR).

What are your rights?

- You have the right to obtain confirmation that your data is being processed, and access to your personal data
- You are entitled to have personal data rectified if it is inaccurate or incomplete
- You have a right to have personal data erased and to prevent processing, in specific circumstances
- You have the right to 'block' or suppress processing of personal data, in specific circumstances
- You have the right to data portability, in specific circumstances
- You have the right to object to the processing**,** in specific circumstances
- You have rights in relation to automated decision making and profiling.

How to complain if you are not happy with how we process your personal information

If you wish to request access, object or raise a complaint about how we have handled your data, you can contact our Data Protection Officer using the details above.

If you are not satisfied with our response or believe we are not processing your personal data in accordance with the law, you can complain to the Information Commissioner at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Email: casework@ico.org.uk

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June 2021

Contents

1. Introduction

Our challenges

1.1. The challenges facing our health and social care system, and indeed health systems worldwide, are well documented (see Figure 1 – Our Health and Social Care System in some numbers).

1.2. Our health and social care system has been under immense and growing pressure for some time. Waiting lists are at an all-time high and we continue to operate within a constrained financial environment.

1.3. Health inequalities continue to persist as we see different outcomes for people in the most and least deprived areas of society. The *Health Inequalities Annual Report 2021*[1] shows that the healthy life expectancy inequality gap in 2017-19 was 13.5 years for males and 15.4 years for females and the rate of emergency attendances in 19/20 for the most deprived areas was more than one and a half times that of the least deprived (see Figure 2 – Some Indicators of our Health and Wellbeing).

1.4. Our population is living longer and with that comes the increased risk of people living with multiple conditions. This adds to the complexity of needs that our services must manage and places additional demands and pressures on the system.

1.5. The pandemic has highlighted serious long established fragilities in our health and social care system. The structure of our current system is having a negative impact on the quality and experience of care that we deliver. This most significantly impacts those who use and deliver the services and there is a fundamental need to change the way we work if we are to transform our services for the better and improve outcomes for individuals.

1.6. Silo working continues to persist and our current configuration does not adequately address the need to improve our working across boundaries and sectors.

1.7. In the 2015 report, '*The Right Time, The Right Place*'[2], Sir Liam Donaldson referred to Northern Ireland having an "ossified model of care", with specialist staffing resources "too thinly spread".

1.8. This was followed by '*Systems not Structures*'[3] published in 2016, endorsed by the then Northern Ireland Executive, which referred to the model of care as "outdated" and "not the one that Northern Ireland needs".

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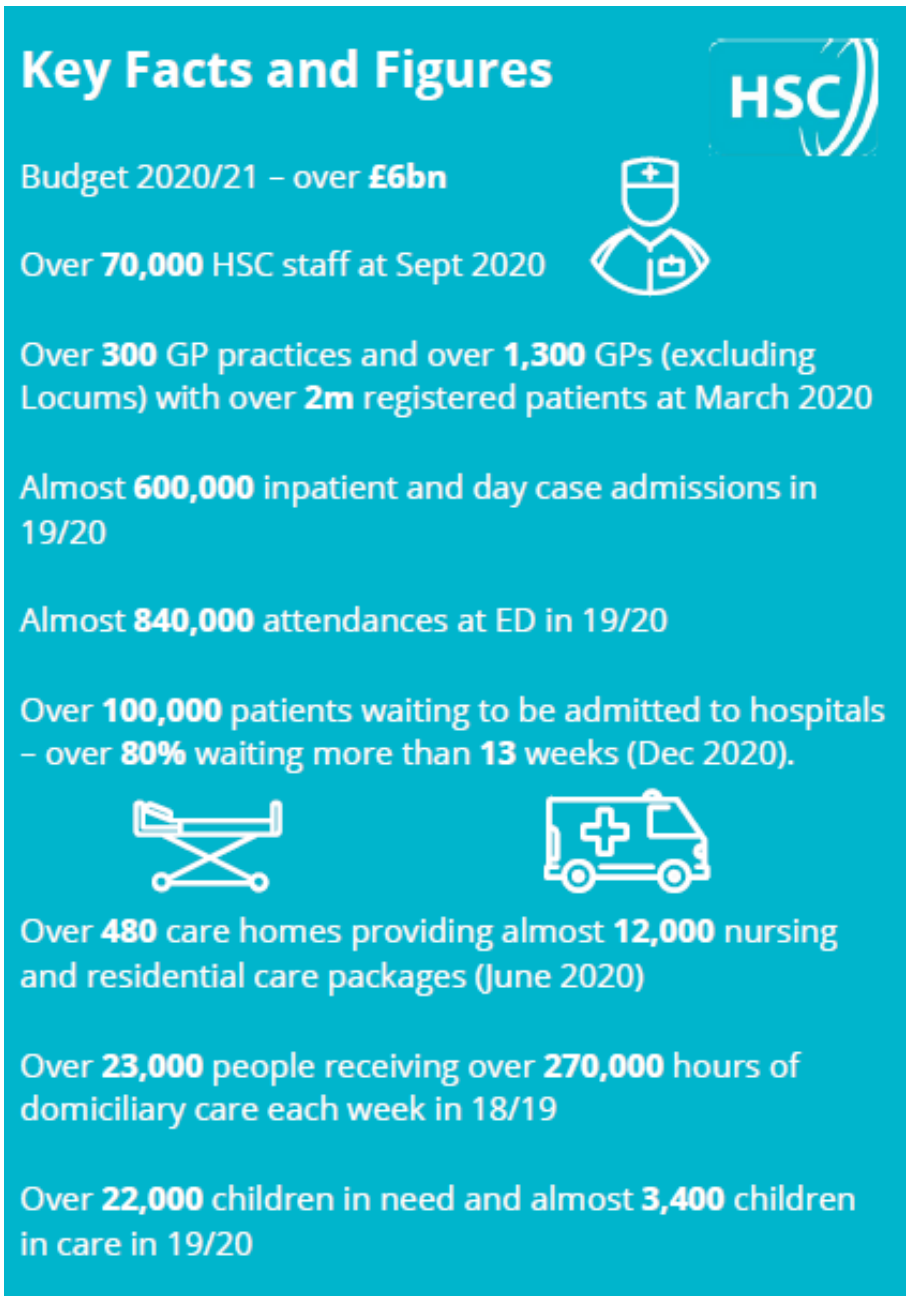
[1] https://www.health-ni.gov.uk/publications/health-inequalities-annual-report-2021
[2] https://www.health-ni.gov.uk/publications/right-time-right-place
[3] https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

1.9. It is widely recognised that addressing the waiting list backlog and reforming services to ensure future sustainability is a complex and long term issue – one that requires recurrent funding commitments. In the meantime we must utilise the existing funding to maximise on the outcomes for our population, through innovation and different ways of working.

1.10. We must address the whole life-course of conditions, from prevention through to intervention and recovery where possible. To do this we must work in a more joined up way with all relevant partners, including those beyond health and social care.

Figure 1 - Our Health and Social Care system in some numbers



Our opportunity

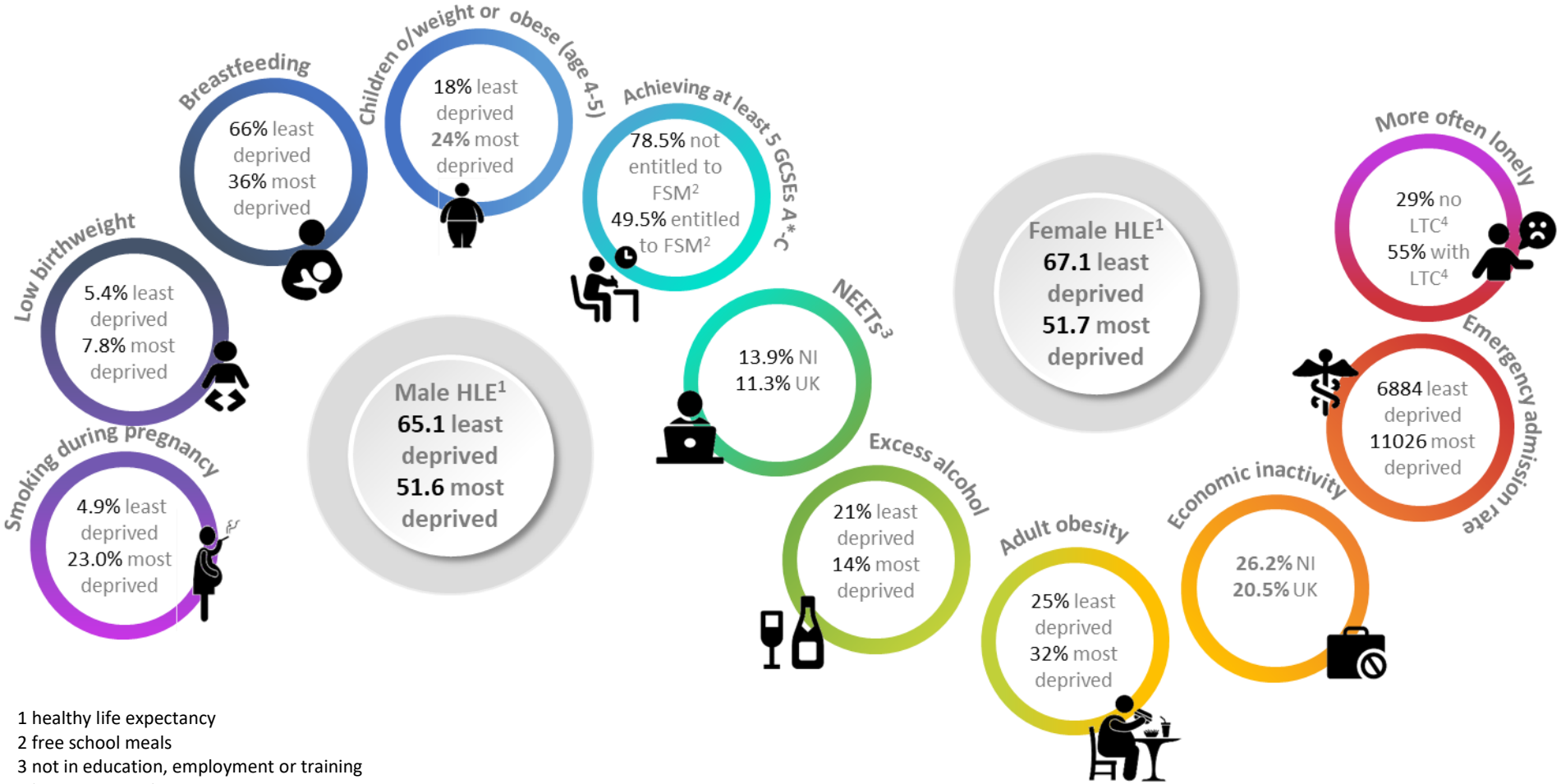
1.11. Whilst it is right to acknowledge and recognise the challenges we face, it is also important to recognise the opportunities that we have in front of us to address these challenges. The response to COVID-19 has provided stark evidence of what can be achieved when we come together to work as 'one system'. Setting aside bureaucratic processes and breaking down the barriers between sectors and organisations has allowed us to deliver responsive and agile services to those most in need.

1.12. We must take the lessons from this approach, and indeed the lessons we have learned over our longer term transformation journey, on the benefits that integrated working can deliver. We already operate in an integrated system under statute. This is a foundation that we must capitalise on. Too often we have reverted to traditional ways of working and of funding services and developments, allowing fragmented approaches to emerge.

1.13. The changing landscape we now find ourselves in provides us with the opportunity to do things differently. The closure of the HSC Board and programmes of work underway to rebuild our services allow us to develop and adopt a better way of planning and managing our services based on collaboration and integration. Importantly, we have a strong foundation on which to build from.

1.14. We can learn and build upon the experience, knowledge and expertise that has emerged from the work of Local Commissioning Groups and Integrated Care Partnerships over the past 10 years, and the developments that have been brought forward under our Transformation programme. The lessons they provide on what has worked, and what has not, when delivering integrated care to meet the needs of local populations will be pivotal as this model develops. Further aligning with wider systems that have emerged, such as Community Planning Partnerships, will help to provide local areas with greater autonomy to maximise on the opportunity to improve outcomes for individuals and communities.

Figure 2 - Some Indicators of our Health and Wellbeing[4]



1 healthy life expectancy
2 free school meals
3 not in education, employment or training
4 long-term condition

[4] Produced by PHA Health Intelligence Unit
Data: HLE 2017-19; smoking during pregnancy, low birthweight, breastfeeding, P1 overweight or obese - all 2019; achieving 5 GCSEs A*-C inc Eng & Maths 2018/19; NEETS Oct-Dec 2020; health survey 2019/20; economic inactivity 2019; emergency admissions per 100k 2019; loneliness 2019/20

2. Strategic Context

Programme for Government

2.1. The Executive is committed to developing a long-term, strategic Programme for Government (PfG) which will build on the Outcomes-Based Accountability (OBA) approach that has defined strategic planning across the public sector since 2016 and government's collaboration and teamwork with key stakeholders and partners.

2.2. The outcomes-based approach encourages people and organisations to think and work outside of their boundaries to solve the wide ranging and long-term issues that relate for example, to education, health and wellbeing, and the economy. By working closely together, partners create strategies and plans that cut across departments and sectors to tackle societal problems and improve wellbeing for all, with an overall focus on outcomes for society.

2.3. The proposed draft *Programme for Government Framework*[5] presents a picture of the kind of society the NI Executive want to see. It clearly sets out the Executive's aim to improve the wellbeing of all of our people. The Framework recognises that we have learned a great deal about working in partnership with others - not just across central government, but with other sectors too, including local government, the private sector and the community and voluntary sectors.

2.4. We must now build on the lessons we have learnt. This is the vision for the Programme for Government and describes the approach which has been taken in the development of this model.

Health and Wellbeing 2026: Delivering Together

2.5. *Delivering Together*[6] sets out a commitment to tackle the issues we face in our Health and Social Care system with an overarching ambition that further reflects the draft PfG outcome for everyone to lead long, healthy and active lives. It sets out the need for a new model of person-centred care focusing on prevention, early intervention, supporting independence and wellbeing.

2.6. This approach is further reflected in *Making Life Better*[7], which provides the strategic framework for public health that contributes to the delivery of the draft Programme for Government and *Delivering Together*. The framework clearly recognises that health and wellbeing, and health inequalities, are shaped by many factors, including

[5] https://www.northernireland.gov.uk/programme-government-pfg
[6] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
[7] https://www.health-ni.gov.uk/publications/making-life-better-strategy-and-reports

age, family, community, workplace, beliefs and traditions, economics, and physical and social environments.

2.7. *Delivering Together* rightly acknowledges that there are limitations within our current structures which impact on our ability to deliver the quality and safety of care that is expected by our population and that there is a clear need to do things differently. Despite having an integrated health and social care system, fragmentation and silo approaches remain which inhibit our ability to transform and properly respond to emerging and identified needs.

2.8. The opportunity to transform how we design, plan, manage and deliver health and social care services must be taken, and *Delivering Together* clearly sets out the approach to do so. The overarching ambition for everyone one of us to lead long, healthy and active lives can be realised by working together to:

- Improve the health of our people;
- Improve the quality and experience of care;
- Support and empower staff; and
- Ensure the sustainability of our services.

COVID-19

2.9. The impact of COVID-19 will continue to affect how we deliver services. It has placed significant pressure on the system and brought into focus many of those factors which underpin the need for change, particularly the health inequalities which continue to persist in our society. The system's response to COVID-19 has shown what can be achieved when people come together to deliver on a common goal. Whilst the challenges are many, there is now an opportunity to bring forward a model for planning and managing services that builds on the learning of the response to COVID-19 and moves forward in a coordinated, joined-up way to realise the benefits and improved outcomes which can be achieved.

Our new approach

2.10. The way we design and deliver services must be focused on providing continuity of care in an organised way. To do so we will increasingly work across traditional organisational boundaries, to develop an environment characterised by trust, partnership and collaboration.

2.11. Local providers and communities must be empowered to work in partnership, including Health and Social Care (HSC) Trusts, independent practitioners, and the voluntary and community sectors.

2.12. This model for planning and managing services provides the potential to harness the strengths of different parts of the system, across organisational boundaries, sectors and beyond what is traditionally considered to be the health and social care sector.

2.13. Working together, partners will plan local care for the populations they serve, informed by need, working towards greater autonomy to make rapid and sustainable improvements and address health inequalities. Some services, for example those that are highly specialised, will be planned at a regional level.

2.14. One of the cornerstone themes for the model is the adoption of the outcomes based approach to improving the health and wellbeing of our population, in line with the draft Programme for Government. This approach will help remove organisational barriers and be a strong driver for the collaborative working practices that are needed to effect real and lasting change and improvement.

2.15. This framework outlines the approach to building the new partnerships which will underpin the planning and managing of HSC services in a way that promotes genuine and meaningful collaboration, integration and improvement. It provides direction on the establishment of the model which will be further developed and built upon in future years.

3. What is an Integrated Care System?

Consultation Question 1: This section (Section 3) describes and defines what an Integrated Care System (ICS) model is which provides the blueprint for how we will plan, manage and deliver services in NI moving forward. Do you agree that this is the right approach to adopt in NI?

3.1. Integrated Care System (NI) is defined as:

A collaborative partnership between organisations and individuals with a responsibility for planning, managing, and delivering sustainable care, services and interventions to meet the health and wellbeing needs of the local population. Through taking collective action, partnerships will deliver improved outcomes for individuals and communities, and reduce inequalities.

3.2. The model enables collaborative working across the HSC sector and beyond in order to reduce health inequalities and deliver improved health and social wellbeing outcomes for our population. It is underpinned by the identification of the needs of individuals and communities and will seek to ensure as far as possible that services are provided in the most appropriate place, at the right time, and in a co-ordinated manner.

3.3. The model enables collaboration, integration and partnerships which reach across traditional boundaries, with organisations, groups and individuals coming together to collectively plan and deliver services and interventions. Involvement goes beyond the HSC sector, bringing in all partners who can help to improve health and wellbeing outcomes, reduce health inequalities, and tackle wider issues which can affect our health and wellbeing. The involvement and knowledge of local communities is the foundation of the model, ensuring decision making is informed by all available evidence and identified need.

3.4. The model is based on the principle of local level decision making which is underpinned by a population health approach with a focus on improving outcomes. The model ensures that local providers and local communities are empowered and enabled to come together to plan care and services for their area. As partnerships are developed and mature this will see increased autonomy, with greater levels of decision making and control over funding devolved to local areas in order to plan for local need.

4. Vision

4.1. The draft Programme for Government is based on a shared and strategic vision for the future which aims to improve wellbeing for all. The Department of Health has lead responsibility for delivering against the outcome that we all enjoy long, active, healthy lives.

4.2. Building on this, the vision for ICS NI is:

> **Delivering together to improve the health and wellbeing of the people of Northern Ireland and enable the population to live long, healthy, active lives.**

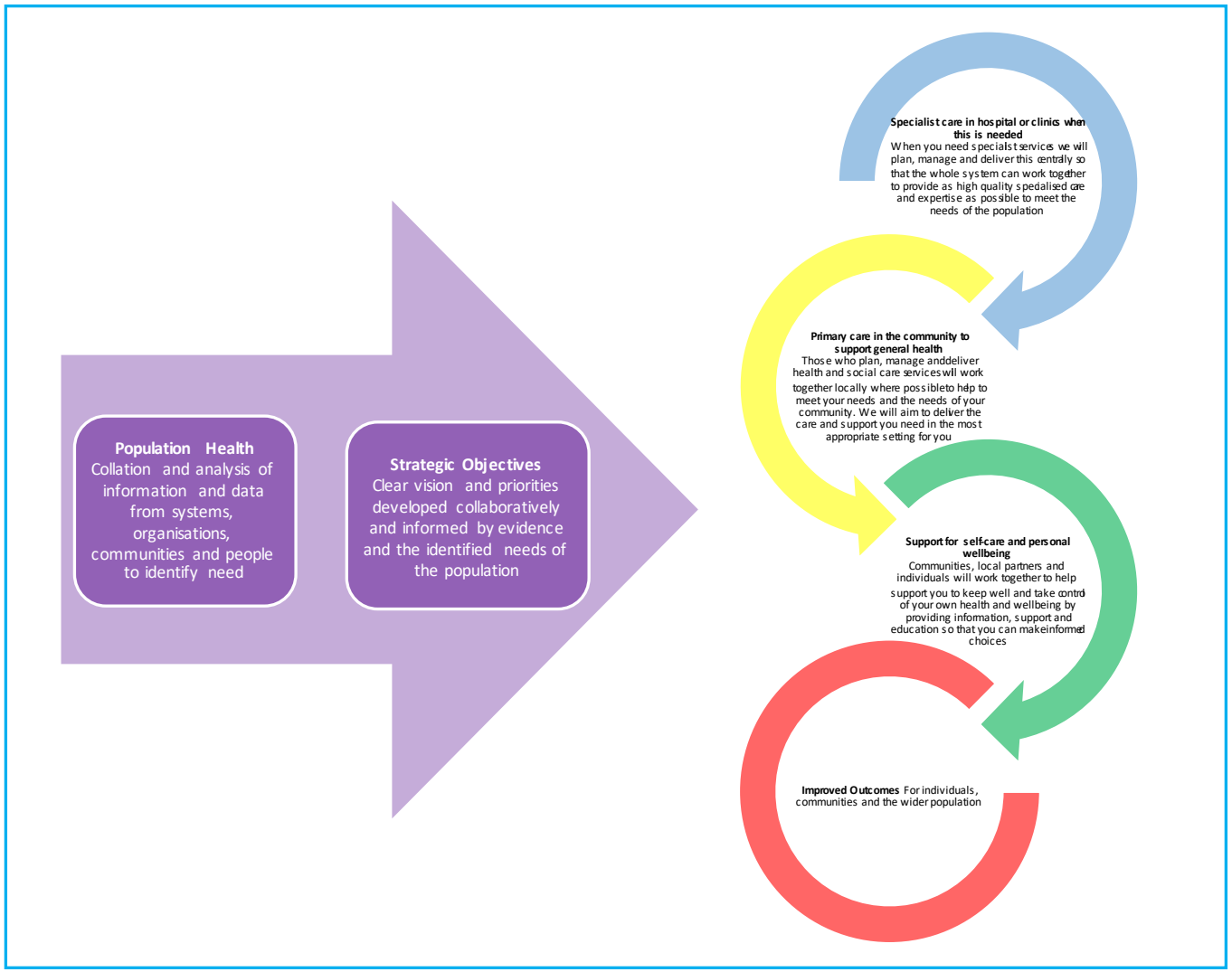
4.3. Our objective is:

To improve health and wellbeing outcomes and reduce health inequalities, through collaboration and partnership in the design, delivery and management of health, social and community services.

4.4. ICS NI will:

- Put the **needs of the people** at the heart of everything we do – planning and delivering services based on population need;
- **Ensure communities** are involved in the planning of services;
- Support people **to manage their own health and wellbeing** and keep fit and well in the first instance;
- **Deliver care within the community**, as far as possible and when it is required and appropriate to do so, avoiding unnecessary visits to hospital;
- **Support people** to manage their multiple and/or long-term conditions;
- **Support and empower staff** to deliver safe and effective services and develop their skills and expertise; and
- **Improve efficiency and optimise capacity**, making the best use of available resources and support sustainability of services and the wider system.

Figure 3 - What does our Vision look like?



5. Values and Principles

Consultation Question 2: This section (Section 5) sets out the Values and Principles that all partners will be expected to adhere to. Is there anything else you think should be included?

5.1. In the model all partners will adopt the following values and principles:

- Ensure the person is at the centre of the model, with services planned and delivered in line with their needs with the aim of achieving improved outcomes for individuals and communities;
- Demonstrate collective and shared leadership to overcome challenges and engage across organisational boundaries;
- Adhere to the principles of parity and inclusion between partners; acknowledging the skills, experience and value that each partner can bring;
- Agree clear and transparent ways of working together, having a mutual understanding of each other's existing governance arrangements and structures;
- Commit to the gathering, analysis, sharing and use of population level data along with known evidence-based interventions to inform decision making and evaluation. This includes the 'lived' experiences of individuals and communities;
- Foster a culture of openness, transparency and trust between partners and the wider population they support;
- Work collectively to remove or avoid duplication, ensuring the most efficient use of available resources and deliver value for money;
- Identify and promote best practice and learning between partners, encouraging flexibility, agility and innovation to collectively meet and address challenges. Use evidence and outcomes to shape local services based on a quality improvement approach.

6. Population Health

6.1. Population health planning has a strong contribution to make to achieving health and wellbeing outcomes. The health and social care system, irrespective of how effective and efficient it is, can only ever address a limited dimension of health and wellbeing. The 'system' needs to have communities and other stakeholders outside of HSC at the heart of planning processes in order to identify and address need, whilst at the same time strengthening cross-government efforts to address the wider determinants of health and wellbeing.

6.2. Population Health is not a new concept. The *Making Life Better* strategy published in 2014 seeks to create the conditions for individuals and communities to take control of their own lives and move towards a vision for Northern Ireland where all people are enabled and supported in achieving their full health and wellbeing potential.

6.3. *Making Life Better* clearly recognises that health and wellbeing, and health inequalities, are shaped by many factors, including age, family, community, workplace, beliefs and traditions, economics, and physical and social environments.

6.4. It details that to achieve better health and wellbeing for everyone and reduce inequalities in health, strengthened co-ordination and partnership working in a whole system approach is required.

6.5. *Delivering Together* reaffirmed this, noting that economic, social and environmental factors, and experiences early in life, play a major role in determining not just the health outcomes at an individual and community level, but also their social, educational, economic and other outcomes.

6.6. *Delivering Together* clearly set out that our future health and social care system needs to not only treat people who become sick or need support now, but also needs to do much more to ensure that the next generation is more healthy with more equitable life opportunities for all.

6.7. There have been significant improvements in the health and wellbeing of the population over decades, however benefits are not evenly distributed: the gap between the most and least affluent parts of our society persists, and in some instances is widening.

6.8. The focus on partnerships and cross-sector collaboration throughout this framework is a recognition of the wide range of determinants of health and wellbeing. New services or interventions created, or existing ones that are transformed, will not always be HSC-owned. Employment levels, housing, community infrastructure and our social networks all influence the population's health and wellbeing. This framework

promotes a population health approach.

Population Health Planning

6.9. The HSC *Making Life Better* partnership developed and agreed a set of principles in 2019 which should be used to guide our work in population health planning. These cover 4 main themes:

<u>Focus on improving the health and wellbeing of a defined population</u>

- Be clear about the population and the population's need;
- Promoting wellbeing and preventing ill-health to be given as much priority as issues of service design and delivery;
- Identify and address inequalities in health;
- Engage across all sectors and levels.

<u>Empower individual communities to take control of their health and wellbeing</u>

- Employ co-production approaches to involve communities throughout planning and implementation;
- Identify, build on and develop the assets available in the community;
- Communicate to build an atmosphere of trust and partnership;
- Be clear on challenges, constraints and choices to be made.

<u>Explicitly address the determinants of ill health and their interactions</u>

- Prioritise relevant population health data including small area data, and service utilisation;
- Develop a shared vision, objectives and measures;
- Base decisions on evidence;
- Create a shared sense of responsibility for health and wellbeing.

<u>Intelligent actions and impact</u>

- Develop and implement integrated actions and strategies that are capable of being delivered;
- Actively use evidence of effectiveness to prioritise action and interventions;
- Advocate, resource and embed effective upstream investment;
- Promote and demonstrate shared accountability with communities and partners for delivering, monitoring and achieving explicit health and wellbeing outcomes.

6.10. As we progress on our transformation journey and building on the work taken forward to date, this model will be underpinned by the population health approach that looks to deliver improved health and wellbeing outcomes for the whole population and reduce the health inequalities which continue to persist in our society.

7. Strategic Direction

Consultation Question 3: In line with the detail set out in this Section (Section 7) do you agree that the Minister and the Department's role in the model should focus on setting the overarching strategic direction and the expected outcomes to be achieved, whilst holding the system to account?

7.1. To inform the overall model, the Minister and the Department will set the overarching strategic direction for health and social care in Northern Ireland, and will set the expected outcomes to be achieved. This will inform the work at each level of the system. It is the Department's mission to improve the health and social wellbeing of the people of Northern Ireland by:

- Leading a major programme of cross-government action to improve the health and wellbeing of the population and reduce health inequalities.
- Supporting interventions on health promotion and education to encourage people to adopt activities, behaviours and attitudes which lead to better health and wellbeing.
- Supporting the population to become more engaged in ensuring its own health and wellbeing.
- Ensuring the provision of appropriate health and social care services, both in clinical settings such as hospitals and GPs' surgeries, and in the community through nursing, pharmacy, social work and other professional services.

Population Profile

7.2. At the initial development stage, a population's health and wellbeing profile will be built using a wide variety of quantitative and qualitative data.

7.3. It will help define the health and social care needs of the population, highlight any health inequalities and by extension shape the Ministerial and Departmental priorities.

Strategic Outcomes Framework

7.4. The identified priorities will be translated into a Strategic Outcomes Framework. The suite of outcomes will be developed along key strategic themes, and be accompanied by associated indicators, which will form the benchmark of the performance evaluation and review process.

7.5. The Strategic Outcomes Framework will be developed with key representative groups and will be subject to its own specific engagement activities. In adopting an outcomes based approach, we must have clarity on what matters to the people of Northern Ireland and what are the priorities we must focus on to improve their health and wellbeing outcomes.

7.6. The Strategic Outcomes Framework will align with the over-arching Programme for Government Key Priority Areas, adopting the Outcomes-Based Approach.

7.7. The Strategic Outcomes Framework will direct the work of each level of the model, and through collaborative working and using the population health approach, local outcomes should be defined that are meaningful to the people in their area, and which are improved via the appropriate planning and delivery of health and social care services.

8. ICS NI Model

Consultation Question 4: This Section (Section 8) sets out what the ICS model will look like when applied to NI. It is based on the principles of local level decision making which will see a shift of autonomy and accountability to local ICS arrangements. Do you agree with this approach?

What will ICS NI look like?

8.1. We are adopting the following approach in applying an ICS model in NI:

Regional level – A Regional Group will provide an oversight, co-ordination and support role for the wider model. The Group will hold responsibility for the associated governance and accountability functions, and the co-ordination of the planning and delivery of regional and specialised services.

Area level – 5 Area Integrated Partnership Boards, 1 per HSC Trust area, with overall responsibility for strategic area planning and local delivery to meet local population needs, guided by a regional strategic outcomes framework.

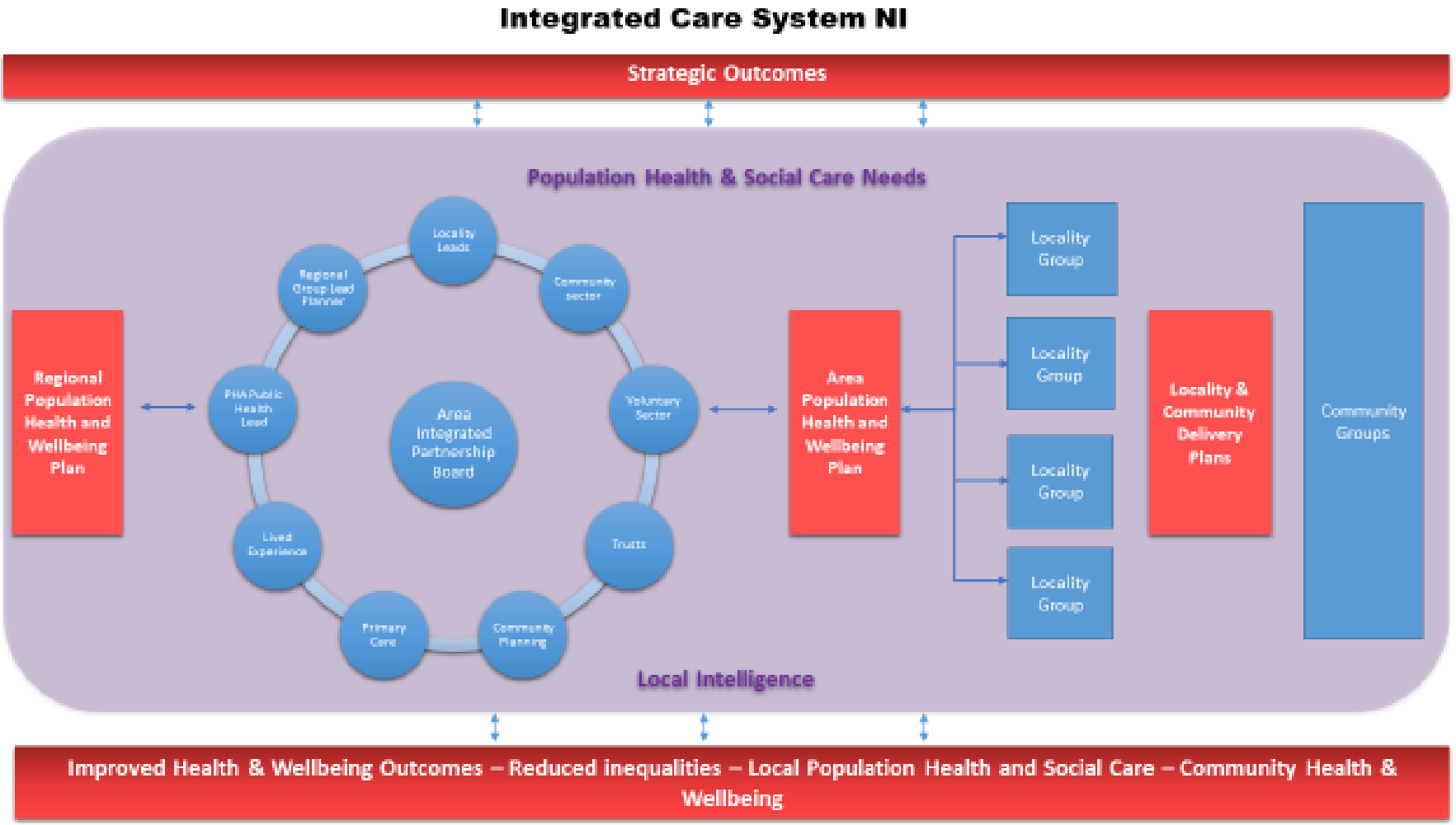
Locality level – covering GP Federation and Integrated Care Partnership areas, and aligning with other relevant areas, such as local councils, where possible. These groups will work to deliver interventions and programmes in each locality as agreed by Area Integrated Partnership Boards.

Community level – focusing on individual towns/local districts, GP practices / MDTs (where established), and community pharmacies, with the potential to align with existing areas such as District Electoral Areas (DEAs) where possible and appropriate. The exact size and number of communities in each Area will be for each Area Integrated Partnership Board to determine.

8.2. The following chapters provide further details on each level of the model[8].

[8] The Area Integrated Partnership Board is not an HSC Trust grouping. All partners participating in the model have equality of influence. The existing HSC Trust boundaries simply provide a segmentation of the population that the HSC system is familiar with and form the basis of the geographical area to be covered by each Area Integrated Partnership Board. This does not preclude cross-boundary working or initiatives where it may be deemed appropriate or necessary for two or more areas to collaborate.

Figure 4 – ICS NI Model[9]



[9] Note: the format and process for Regional / Area / Local plans will be subject to further detailed consideration and development and additional guidance will be provided in due course

9. Regional Level – Regional Group

Consultation Question 5: As detailed in Section 8 and this Section (Section 9), a Regional Group will be established to undertake an oversight, co-ordination and support function for the ICS. Do you agree with this approach?

What is the Regional Group and its role within the model?

9.1. The Regional Group will be established under the direction of the Department of Health, and in partnership with the PHA, will undertake the below objectives.

- To provide support to the Area Integrated Partnership Boards in their initial establishment and ongoing operation;
- Put in place clear and robust governance and accountability arrangements with the Area Integrated Partnership Boards;
- Plan, manage and co-ordinate the delivery of regional and specialist services;
- Provide an oversight function in relation to equity of access to services and quality of care across the system, working to remove regional variation and duplication where appropriate and beneficial; and
- Lead the co-ordination and sharing of best practice between and across areas, sectors, organisations and partners, ensuring there is clear mechanisms in place to do so.

How will the Regional Group operate?

9.2. The Regional Group will undertake the following:

- Support the establishment of Area Integrated Partnership Boards and their ongoing operation. This includes supporting the establishment of the relevant partnerships between organisations and sectors;

- The production of an annual Regional Population Health and Wellbeing Plan in response to the strategic direction set by the Minister and the Department (or on a timescale as otherwise directed), informed by local intelligence and population health needs;

- The commissioning of annual Population Health and Wellbeing plans (or on a timescale as directed) from each Area Integrated Partnership Board for submission and approval to the Regional Group which align with the regional

plan and account for delivery against identified local needs;

- Monitoring of the overall performance of each Area Integrated Partnership Board against approved work plans and against agreed outcomes, indicators, measurements, in line with the Outcomes Based Accountability approach, and targets (where appropriate);

- Provide support for Area Integrated Partnership Boards by taking a co-ordinating role in terms of system-wide and regional priorities which seek delivery at a the local level and supporting shared learning between local Areas; and

- Co-ordinate of the planning and delivery of regional and specialised services. This will include the need to produce clear guidance and/or criteria on what falls under the regional remit, and therefore what can or cannot be delivered or developed by Area Integrated Partnership Boards autonomously.

How will the current HSCB operate and support this work?

9.3. The model will be developed during 2021 in advance of the proposed closure of the HSCB on 31 March 2022. During this period the HSC Board will still continue to operate and undertake their statutory roles and duties in aspects of commissioning, governance, accountability and finance. The HSCB will support the development of this model throughout this period and will work closely with colleagues on both regional and local aspects. This will include working closely with existing Local Commissioning Groups on the development, implementation and transition to the new approach.

How will the PHA support this work?

9.4. The PHA will also continue to deliver its statutory duty in relation to commissioning in the new model. The PHA will also have a lead role in the development, implementation and operation of the model. As a core partner, the PHA within its statutory Public Health responsibilities will co-lead the development of the population health approach (through its health protection, health improvement and population health intelligence functions) as well as providing professional leadership and expertise in the planning process at regional and local levels.

10. Area Level – Area Integrated Partnership Boards

Consultation Question 6: As detailed in Section 8 and this Section (Section 10), do you agree that the establishment of Area Integrated Partnership Boards (AIPBs) is the right approach to deliver improved outcomes at a local level?

Consultation Question 7: This Section (Section 10) of the framework provides further detail on the local levels of the model, including the role of AIPBs. Do you agree that AIPBs should have responsibility for the planning and delivery of services within their area?

Consultation Question 8: Do you agree that AIPBs should ultimately have control over a budget for the delivery of care and services within their area?

What is the aim of the Area Integrated Partnership Boards?

10.1. The overarching aim of each Area Integrated Partnership Board is to deliver improved health and social care outcomes and reduce health inequalities for their local population areas based on a population health approach and through improved integrated working across sectors and boundaries in the planning, delivery and management of services. This will be undertaken in line with the agreed strategic direction and priorities. This will include:

- Building relationships and trust between leaders; encouraging shared responsibility and accountability for collective gains and risks;
- Providing clear leadership for the area on the direction of travel and priorities to be addressed, supporting and enabling partners to deliver against agreed outcomes; and
- Encouraging genuine partnership working at *Locality* and *Community* levels and across all partner organisations.

What are the structures in each Area?

10.2. Each area will consist of the following:

- An **'Area' level Integrated Partnership Board (AIPB)** –with responsibility for overseeing the work of the integrated care partnership in its area and the governance of all affiliated structures. Each AIPB will provide the local direction and priorities for its area, in line with the strategic outcomes set by the Minister and the Department. The AIPB will take into account the identified needs of its local population. The AIPB will have wide representation from constituent organisations (see paragraph 10.6) and will be accountable to the Regional Group in terms of the development, delivery and monitoring against an agreed work plan.

- **'Locality' level structures** to support the work of the AIPB. The exact number and role of the groups at this level will be determined by the AIPB. However, they should be based around existing GP Federations and Integrated Care Partnership areas, and should also align and integrate with local Council structures (Community Planning Partnerships) and boundaries wherever possible. AIPBs must utilise the knowledge and expertise already in operation within each area. This approach will provide consistency across the region and will ensure the most efficient use of existing resources.

- **'Community' level structures** are also to be determined by each AIPB. The number, size, and area(s) covered should reflect the most appropriate structure for each *Locality*. For example, it may be useful to base these around local or individual GP practices and MDTs (where established), community pharmacies or local community groups or organisations. The key is to ensure that any groups at this level contribute effectively to and assist with the work of the AIPB.

Who is part of the AIPB?

10.3. Representation on the AIPB **must** be wide and in line with the membership requirements detailed below. The principles detailed in this document (see Chapter 5) should be applied at all times. This wider engagement and involvement must move forward and be established from the outset.

10.4. A significant part of this will include strengthening partnerships within the HSC itself. In particular the relationship between Trusts and GPs has been highlighted as pivotal to enable successful partnership working across all sectors. Further detail on what is meant by this is included in **Appendix A**. Some areas have already established such partnerships and others may wish to also explore what can be done between these key partners. Such partnerships must sit alongside and support the work of the wider model and should not be viewed as an alternative approach.

Consultation Question 9: As set out in this Section (Section 10), do you agree with the proposed minimum membership of the AIPBs?

Consultation Question 10: As set out in this Section (Section 10) of the framework (and noting the additional context provided in Annex A of the document), do you agree that initially each AIPB should be co-chaired by the HSC Trust and GPs?

Consultation Question 11: The framework allows local areas the flexibility to develop according to their particular needs and circumstances. As set out in this Section (Section 10), do you agree that the membership and arrangements for groups at the Locality and Community levels should be the responsibility of the AIPBs to develop, determine and support?

Membership of the Area Integrated Project Board

10.5. In the first instance and to enable implementation, each local AIPB must be co-chaired by the Chief Executive of the relevant HSC Trust and a nominated lead representative of General Practice in the area. For the avoidance of doubt, whilst this approach will be adopted initially, the chairmanship should be for each AIPB to determine moving forward and should be open to all members.

10.6. The framework is not prescriptive on exactly who must be a member of the groups at the local levels. However, the membership of the AIPB must include leadership from the following as a minimum:

- HSC Trust Chief Executive
- 3-4 GP Leads – 1 Federation Support Unit lead, 1 GP Medical lead, 1-2 Local Medical Committee leads
- 4 Trust Directors covering Planning, Nursing & AHPs, Social Services, and Medical
- 1 Lead from Community sector
- 1 Lead from Voluntary sector
- 1 Lead from each Community Planning Partnership within the AIPB area
- 1 Carer representative

- 1 Service User
- 1 Community Pharmacist Lead
- 1 Regional Group Lead (specific to each AIPB)
- 1 PHA Director / Assistant Director (specific to each AIPB)
- 2-4 Locality Partnership chairs (depending on area and make-up of *Locality* structures)

10.7. Each AIPB may consider additional membership, either permanent or on an ad-hoc basis as they deem appropriate, for example from specific specialisms, professional bodies or local bodies, but core membership must include the above. Each core member should ideally be in a position to provide a collegiate viewpoint for their relevant profession, area or sector, and be of sufficient seniority to contribute to decision making at meetings and enable successful implementation of agreed system wide changes.

10.8. Membership and arrangements for groups at the *Locality* and *Community* levels is to be determined by the *Area* level AIPB, in line with the guidance noted above.

10.9. It is the responsibility of each *Area* level AIPB to clearly define the links between the *Community, Locality* and *Area* level structures. This should include clarity on how the different tiers interact, their specific roles and responsibilities in their local area, and clear governance procedures for gathering intelligence, reporting and monitoring, and degree of autonomy.

10.10. Note that further detail and information with regards to partnership working, and in particular the engagement of non-HSC sectors, is included at **Section 11**.

What skills/experience should members of each AIPB demonstrate?

10.12. For an integrated care system to realise its potential, it is important those nominated to sit on an AIPB have the relevant skills and experience to provide a sound foundation on which to build a new way of working.

10.13. Integrated care reflects an approach to planning, managing and delivering services based on collaboration and partnership and reflects a shift of focus away from the traditional silo approach to one of connectivity, alignment and integration.

10.14. It is essential that those involved not only have the relevant skills and expertise in their own area but can demonstrate the ability to work in partnership across organisations and professions to deliver shared outcomes. They must be able to build and maintain strong effective relationships both formally and informally, demonstrating an empathy with those with whom they are connecting with.

10.15. Leadership is key at all levels of the ICS and with that the ability to think strategically with a systems focus to achieving outcomes is paramount.

What must each AIPB produce?

10.15. The overall work of the AIPBs will be co-ordinated and overseen by the Regional Group, however they will be granted as much autonomy as possible to allow for local approaches to delivering on desired outcomes.

10.16. There are some things that each AIPB must do:

- Create a suitable partnership agreement for each AIPB at *Area* level to formalise and underpin the work of the group – this should be ratified by the Regional Group in advance of **1 April 2022**;

- Each AIPB must develop a Decision Making Framework for their *Area*, detailing how decisions will be made to provide clarity and transparency between the local levels. This should be ratified by the AIPB in advance of **1 April 2022**;

- Produce a Terms of Reference for each AIPB at *Area* level to be ratified by the Regional Group in advance of **1 April 2022**;

- Each AIPB must produce a Population Health and Wellbeing Plan for approval to the Regional Group on an annual basis (or on a timescale as directed) detailing how and what the AIPB will do to deliver against the agreed strategic direction and desired outcomes within their area; and

- Provide regular updates as requested by the Regional Group in relation to performance management in order to measure the success and impact of services, interventions and progress against the agreed work plan.

11. Locality and Community Levels

Locality Level

11.1. The *Locality* level structures should be based around existing GP Federations and Integrated Care Partnership areas and should align with those of other organisations, e.g. Local Councils/Community Planning Partnerships, where possible. It allows a wider representation from all health and wellbeing interested organisations into the planning and delivery of services at a more local level. Priorities will include those decided at the *Area* level or more local initiatives as agreed. The number of *Localities* may change in each area depending on their present needs and local support. It includes:

- Organisations working together to integrate care, address health inequalities and monitor performance and quality;
- Delivering against agreed outcomes in line with strategic plans agreed at *Area* level;
- Actively promoting the inclusion of third sector organisations, communities and the wider public sector into the Health and Care agenda for all their population; and
- Feeding into the *Area* level; informing and influencing strategic planning with the aim of improving the health and wellbeing of their local population.

What must each locality group produce?

11.2. Provide a local delivery plan for approval to the AIPB at their *Area* level on an annual basis (or on a timescale as directed) detailing how and what the locality group will do to deliver against the agreed AIPB direction and desired outcomes within their area.

11.3. Provide regular updates as requested by the AIPB at *Area* level in relation to performance management in order to measure the success and impact of services, interventions and progress against the agreed delivery plan.

Community Level

11.4. The *Community* level aims to involve individuals and community leaders in the process of helping people manage their own health and wellbeing with appropriate support; and to access health and care services within their own community. It also helps to co-ordinate and maximise community and voluntary support for its own citizens. It seeks to ensure that plans and initiatives from R*egional* and *Area* levels are delivered locally with fairness and efficiency. This includes:

- Promotion of a “community ethos” for health and wellbeing by aiming to join up care at this level and recognise local representatives and champions for that community;

- Valuing the assets of the community including organisations, networks, resources etc. and building with them by supporting their capacity and sustainability; and
- Empowering grassroots initiatives and projects where suitable; and with resources if possible.
- Optimising the utility of all commissioned family practitioner services.

12. Partnership

Agreements and contracts

12.1. The model is underpinned by the development of partnerships between people and between organisations. In many cases these will be informal and rely on the relationships and individuals involved, or in other cases there may be existing statutory, contractual or other obligations and agreements that dictate certain interactions and relationships.

12.2. Those involved with the model must explore and utilise the various options available within any existing constraints to put in place more formal agreements to provide clarity of approach and which can formally reinforce the commitment of the relevant partners in any given arrangement. There must be a willingness to embrace the concept of shared authority, accountability, and risk.

12.3. Options to explore and develop may include, but are not limited to:

- Memoranda of Understanding
- Service Level Agreements
- Lead Provider Contracts
- Alliance agreements/contracts
- Charters

12.4. This framework does not place any specific requirement around such arrangements, other than the requirement for there to be a formal agreement in place to underpin the *AIPB* in each area. Otherwise each *Area* is free to proceed as they deem appropriate. Any examples of useful or innovative approaches that have proved effective should be shared between areas as examples of best practice.

Wider engagement and representation

12.5. This document stipulates membership from specific areas / professions at the *Area* level, it is acknowledged that there is likely scope to improve upon what is initially achievable in terms of broader representation and engagement.

12.6. As an example, having one, or even two representatives from the Voluntary and Community sectors or representing service users or carers, would meet the requirements as set out in the framework. However, the ability of these representatives to fully reflect the views, opinions, and position of all relevant partners in their sector / area is likely to be limited given the broad range of organisations and interests that exist.

12.7. The same is applicable to any of the partners or professions involved in the model, such as those acting as a member of the *Area* level AIPB, whereby the networks and infrastructure to allow members to represent their entire sector may not exist or be fully developed.

12.8. The intention for each partner who acts as a member of the *Area* level AIPB, is to have the ability to bring forward the views of their sector/profession/organisation as a whole on general topics, and those views which may be relevant to specific specialities or topics. It is anticipated more formal arrangements will be required to support and facilitate this approach.

12.9. It is incumbent upon all partners involved in the model to work together to identify where this type of infrastructure is required or has potential to be developed, in order to enable genuine and comprehensive representation from all partners.

12.10. For example, a Partnership Forum or Partnership Board for a given profession or sector could be used to sit alongside the structures. Such a forum would be responsible for collating and securing the views of their sector, and be able to provide one or 2 nominated individuals as formal members of the *Area* level AIPB.

12.11. A Partnership Forum will not only seek to bring the views and input of wider sectors, but also provide a formal structure to highlight, acknowledge, and promote the resources and capacity that exists within the sector in order to contribute to, and take ownership and shared responsibility for achieving the aims and outcomes in line with the wider strategic direction.

12.12. If such a forum is not already in existence within a given local area, formal arrangements and support should be established to ensure full and meaningful representation moving forward. Where a forum or similar arrangement exists, it should be engaged from the outset.

12.13. It is important the right support and structures are put in place to foster this level of engagement to the benefit of the model, the local population and community. Local areas should adopt an approach that meets their specific needs and the needs of their partners and their local population. It is important to highlight that before establishing any new systems or adopting any new approached, efforts should focus on identifying, building on, and utilising any existing local or regional resources and structures.

13. Governance and Accountability

13.1. Each organisation and body involved in the model will have existing governance and accountability structures, mechanisms and obligations, including those set out in statute.

13.2. The governance of a new system with the associated devolution of autonomy of decision-making and funding will be addressed as the model matures.

13.3. In broad terms, the following will be in place:

- A clear strategic direction with expected outcomes set by the Minister and the Department, published in draft by **1 April 2022**. In essence this replaces the current Commissioning Plan Direction and will provide a high-level overview of the key priorities that must be delivered by the wider system.
- A response to this strategic direction, developed by the Regional Group, which sets out how the wider system will deliver against the priorities and improve outcomes for the population. This will include detail on the financial and budgetary position as well as how performance and success will be monitored, and effectively replaces the existing Commissioning Plan.
- Each AIPB will develop a work plan / joint delivery plan for their area in line with the strategic direction. This will look to deliver against the key priorities and will take account of local population needs. This will be reported to, and require approval from the Regional Group.

Governance

13.4. Within the above there will be a need to develop suitable governance arrangements at more local levels and in relation to specific areas. The following should be taken into account when considering what is required:

- Partner organisations must continue to contribute to existing governance structures and arrangements and this should be reflected in any arrangements agreed between partners;

- *AIPBs at Area* level should consider creation of an overarching governance strategy for their local area. The aim is to provide clarity on requirements and expectations, and how their process and procedures contribute to the overarching governance arrangements;

- As noted previously (see **Section 9.21**) an *Area – Locality – Community* decision-making framework must be developed by each *Area* group to provide clarity across the tiers on roles, responsibilities and where the power to make specific decisions lies;

- Opportunities must be taken to consolidate existing arrangements where possible and remove any duplication that may emerge as a result of greater integration and collaboration; and

- AIPBs should explore and develop new arrangements where this is beneficial to governance processes, and take steps to clearly understand the requirements of all partners both in terms of the work undertaken by the AIPB, and what is required within individual organisations. An example could be the formation of an oversight or assurance group which can monitor delivery against work plans, measure outcomes and provide overviews of financial positions.

Accountability

13.5. It should be acknowledged from the outset that accountability that crosses organisational and sectoral boundaries is complex. The model allows for exploration of how collective accountability can be more embedded in the culture and practices of the system.

13.6. Responsibility for individual organisations to continue to manage and report on their own performance will remain and accountability in that respect will not be immediately changed or altered. Statutory obligations must continue to be met and adhered to.

13.7. However, the ambition of the ICS model is to mature and develop collective accountability, with the management of performance and risk becoming an increasingly shared responsibility.

13.8. Partners should be encouraged and supported to move towards this approach, utilising the trust and relationships that will develop in time to provide assurance that all partners can enter into arrangements which look to find solutions where issues may arise, as opposed to apportion blame.

13.9. Innovative approaches should be encouraged and explored to find ways in which to promote this model.

13.10. The culture of collaborative working begins at the highest levels of the system and filters down to local levels. This can be tracked back to one of the key principles at the outset of this framework – that the needs of the person must be at the centre of what we do, and that we are working in partnership to deliver improved outcomes for individuals, not in isolation. Taking collective responsibility to deliver that purpose will require collective accountability.

14. Finance and budgets

14.1. The model will result in increased autonomy at a local level, and as the model and partnerships mature, it will see AIPBs take control over the planning and funding for services delivered within their localities.

14.2. What this means is that the model will be underpinned by a funding approach which will put local areas in control of a central resource which they will be collectively responsible for allocating and managing cost effectively to achieve improved health and wellbeing outcomes for their local population. Funding will not automatically rest with individual organisations or services, rather it will be for the AIPB to agree where and how resources should be utilised to address identified need.

14.3. However, the development of a new funding model to facilitate this approach is a complex undertaking and will take significant time and resources to achieve.

14.4. It is for this reason that no substantial changes are being proposed to current financial models, processes or procedures in the first instance. Additional guidance on any new funding approaches will be added to this framework as an addendum when developed and agreed.

14.5. Whilst changes in this area will not be undertaken at a system wide level at this time this does not preclude any organisations from exploring new approaches to utilising funding that helps to deliver against the strategic vision and is in line with the approach of integration and collaboration. Where there are local opportunities to pool resources these should be encouraged and developed.

15. Maturity & Future

15.1. The key aim of this initial phase is to establish the structures and arrangements as set out in this framework. Moving forward it is the ambition to build upon this work to further develop the model, identify lessons learned and areas for improvement.

15.2. As part of this work, there will be a need to develop a maturity matrix for local *Area* structures which clearly sets out the stages and levels at which increased autonomy can be achieved, and the requirements to earn increased autonomy.

15.3. Further work will be taken forward to establish whether more formal mechanisms are required within the model, such as whether the AIPBs should have more formal appointment arrangements. Early work will also help to identify if there is any requirement to underpin the model with specific legislation, or whether it operates more successfully under the broader existing provisions.

Appendices

Appendix A – What is meant by a Trust/GP Partnership?

- It is recognised that, while each AIPB must be fully inclusive from the outset, the building of strong partnerships within health and social care is crucial to its success.

- Population health policy can only succeed where the HSC service has developed healthy collaboration between its hospital and community sectors. Integrating and building parity within the bodies making up the HSC partners is fundamental to the HSC being better placed to partner with others.

- It is not about which profession or group is most important, rather it is a recognition of the way the system currently works and what is required to maintain accountability and integrated service delivery. If the sectors do not have a shared framework for collaboration and partnership embedded within and across the whole HSC service, then that system will remain fragmented and attempts to build a wider partnership with all partner bodies involved within the model will be piecemeal and ineffective.

- The internal HSC partnership becomes the foundation for wider collaboration and the development of productive relationships with a broader group of partners, essential to improving the health and wellbeing of the population.

- The partnership should initially include GPs, Trust professionals and leaders who have experience and vision to pursue active and healthy relationships with each other, improve or join up service delivery, share responsibility and improve user experience.

- The Trust/GP partnership should be supported by a clear written agreement. This should be incorporated within the wider required Area level partnership agreement. The professional leads across the sectors should carry standing and representation amongst their peers and be willing to develop new ways of working.

- It is also vital that the Trust/GP partnership, whilst an important preparatory step for the establishment of the model, is not seen as an exclusive 'inner circle' but rather an enabler for effective broader partnership. All levels of a functioning ICS need appropriate inclusion, parity of esteem, and equality in terms of influence on decisions.

Glossary of terms

Allied Health Professional (AHP)	Within DoH the term "allied health professions" refers to the following 12 professional groups: arts therapy, dietetics, occupational therapy, orthoptics, physiotherapy, podiatry, prosthetics, radiography, speech and language therapy, drama therapy, music therapy and orthotics.
Carer	Carers are people who, without payment, provide help and support to a family member or friend who may not be able to manage at home without this help because of frailty, illness or disability.
Commissioning	Commissioning is the purchasing of HSC services to meet the health needs of the local population.
Commissioning Plan Direction (CPD)	The Department of Health sets out the Minister's instructions to commissioners in an annual commissioning plan direction.
Community Care	Locally based health or social care services provided to patients in and around their home.
Community Planning Partnerships (CPP)	Established in each local district comprising the council, statutory bodies, agencies and the wider community, including the community and voluntary sector, who develop and implement a shared plan for promoting the well-being of an area, improving community cohesion and the quality of life for all citizens.
Early Intervention	Early intervention services are specialist services that provide treatment and support for people who are experiencing early symptoms of an illness. The aim is to provide low level support to prevent the person developing more acute needs at a later stage.
Family Practitioner Service (FPS)	Family Practitioner Services is a collective term for General Medical, Dental, Ophthalmic and Pharmaceutical practitioners across the province.
General Practitioner (GP)	GPs are primary care doctors providing the first point of contact with the HSC for most people in their communities.
GP Federations	A group of general practices or surgeries forming an organisational entity and working together within the local health economy to aim to provide better care, delivered in a more responsive way and closer to home. There are currently 17 fully incorporated GP Federations covering all areas of Northern Ireland.

Health and Social Care (HSC)	*This is an umbrella term for Health and Social Care services in NI.*
Health and Social Care Board (HSCB)	The organisation responsible for commissioning health and social care services in NI.
Health Inequalities	Health inequalities are avoidable, unfair and systematic differences in health between different groups of people.
HSC Trusts	The HSC Trusts are the main providers of health and social care services to the public as commissioned by the HSCB.
Integrated Care	A concept that brings together the delivery, management and organisation of services related to diagnosis, treatment, care, rehabilitation, and health promotion in order to improve services.
Integrated Care Partnership (ICP)	ICPs are collaborative networks of care providers, bringing together healthcare professionals (including doctors, nurses, pharmacists, social workers, and hospital specialists); the voluntary and community sectors; local council representatives; and service users and carers, to design and coordinate local health and social care services.
Local Commissioning Group (LCG)	LCGs are committees of the Health and Social Care Board (HSCB) and are responsible for the commissioning of health and social care by addressing the care needs of local populations.
Multi-Disciplinary Team (MDT)	A group of professionals from diverse disciplines who come together to provide comprehensive assessment and management.
Northern Ireland Ambulance Service (NIAS)	NIAS provides high quality emergency, urgent and primary care services throughout the whole of Northern Ireland.
Outcomes-Based Accountability (OBA)	An approach which seeks to place the wellbeing of a population at the heart of policy and decision-making by defining agreed outcomes for a given population, and driving all work towards progressing these outcomes. The approach works on two distinct levels: the higher and broader level of population accountability, and the lower and more specific level of performance accountability.
Patient and Client Council (PCC)	The PCC provides a powerful, independent voice for patients, clients, carers, and communities on health and social care issues.
Person-centred care	An approach to working with people that puts the needs and aspirations of the individual firmly at the centre of the process.

Population Health	An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities.
Public Health Agency (PHA)	The PHA is a regional organisation for health protection and health and social wellbeing improvement. The PHA is committed to addressing the causes and associated inequalities of preventable ill-health and lack of wellbeing.
Voluntary and Community Sector	An umbrella term referring to registered charities as well as non-charitable non-profit organisations, associations, self-help groups and community groups.